

DECLARATION OF INCOME STATEMENT

I, _____ do hereby declare on _____ that:
Applicant's Name date

There is no documented proof of income for me and/or the following household members for the following reason(s):

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I am applying for assistance with **Travis County Health and Human Services and Veterans Service Department**.

My household consists of _____ persons and the following household members, 18 years and older that have earned the following undocumented gross income during the 30 day period prior to the date of this application for assistance.

Name		Gross Amount	
Name		Gross Amount	
Name		Gross Amount	
Name		Gross Amount	
Name		Gross Amount	

I certify that the information for the income of the household members listed above, 18 years and older is true and correct to the best of my knowledge and belief.

I understand that the information will be verified to the extent possible; and that I may be subject to prosecution for providing false or fraudulent information.

Signature of Person Making Statement date

Printed name, signature and relationship of person assisting with statement date

State of **TEXAS**
County of **TRAVIS**

Before me, a notary public, on this day personally appeared _____ known to me through _____ to be the person whose name is subscribed to the foregoing document and, being by me first duly sworn, declared that the statements therein contained are true and correct.

Given under my hand and the seal of office this _____ day of _____ 20_____.

(Personalized Seal)

Notary Public's Signature

To Be Completed by Travis County Staff:

CLIENT NAME _____ CABA # _____

This household consists of _____ persons **Household's gross program income**, for all household members 18 years and older, for the **30 day period** prior to the date of the application for assistance is \$ _____;

Income Documentation-Detail "30 days income"

and **household's gross annualized program income** based on the **30 day period** prior to the date of this application is \$ _____

Income Documentation-Detail "annualized"

Signature of Caseworker date

Signature of SSPA date